VERMONT

DOL FORM 2 Rev. 6/05

State File No. _____

Ins. Co. File No.

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

Denial of Workers' Compensation Benefits by Employer or Carrier

Your employer has filed this denial in accordance with Vermont Workers' Compensation Rule 3.0900. Notice must be sent to the injured worker and the Department of Labor. Supporting evidence must be attached.

TO:

Claimant's Name: _____ Soc. Sec. No. _____

Address: _____ Telephone No. _____

Employer: _____

Date Notice Received: _____ Date of Injury: _____

Nature of Injury: _____

REASON(S) FOR DENIAL: _____

Attach additional pages if necessary.

DOCUMENTATION ATTACHED: (List) _____

ISSUED BY:

Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No. _____

Adjuster Signature: _____ Employer: _____

NOTICE and FORM for EMPLOYEE to APPEAL DENIAL

In accordance with 21 V.S.A. §656 and §660 and Vermont Workers' Compensation Rule 3.0550, an employee has six months form the date of injury to file a claim. The date of injury is the point in time when the injury and its relationship to the employment is reasonably discoverable and apparent. A claimant may pursue a claim after the six months if the claimant can show that the employer, the employer's agent or representative had knowledge of the accident, or that the employer has not be prejudiced by the delay or want of notice, but in not event may proceedings be commenced more than six years from the date of injury.

TO APPEAL, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE (for example, doctor's notes, emergency room records, any other medical records such as physical therapy, radiology reports, etc. or witness statements) TO SUPPORT YOUR INJURY AROSE OUT OF YOUR WORK. KEEP A COPY Of the FORM FOR YOUR RECORDS AND MAIL A COPY OF THIS FORM TO:

Vermont Department of Labor, Workers' Compensation Division,
National Life Building, Drawer 20, Montpelier, VT 05620-3401

Did you notify your employer/supervisor of the injury/illness? Yes _____ No _____

Briefly explain how the injury/illness occurred (attach additional pages if necessary)

_____

Did you lose time from work because of the injury? Yes _____ No _____

If yes, on what date did you begin losing time from work? _____

If you have returned to work, indicate the date on which you returned _____

I am seeking all worker's compensation benefits allowed by law. _____

Employee Signature

If you have further questions please call or office at (802) 828-2286 or check our web-site at www.labor.state.vt.us.

Equal Opportunity is the Law. The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711(TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).